TOPIC: HEALTH CARE ACCESS AND MEDICAID

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Health care has been a top concern for Texans for decades. The COVID-19 pandemic has increased anxiety about cost, access, and quality but it has also increased opportunities for reform.

In this moment of reinvention, Texas has a remarkable opportunity to reduce costs and stress for patients across Texas by increasing price transparency, diversifying options for care, and promoting competition. I appreciate the opportunity to provide this written testimony and share ideas about how to improve health care in Texas.

Expand Association Health Plans (AHPs)

416,000 small companies in Texas face paying very high insurance premiums in the state—often with significant deductibles.[1] Allowing more of them to band together to purchase coverage like larger companies not only saves them money, but also grants them access to more innovative plan designs and more insurance options, helps them see the return on investment when they invest in wellness, and increases the number of people to whom they offer coverage.

Expanding access to AHPs should be a priority as an estimated 368,000 Texans could access these more flexible and affordable options.[2]

States have a unique authority to regulate self-insured Multiple-Employer Welfare Arrangements (MEWA) and expand access to AHPs, regardless of any federal legal challenges. Some suggested changes to current law include[3]:

1. Broaden geographically based MEWA options. This would allow business groups with a common interest but representing multiple industries (for example, all the female-owned businesses in Texas) to form an AHP. This would require a change to section 846.053.

2. Eliminate the two-year-in-existence requirement. This creates a significant waiting period between the time an association forms and the time it can offer an AHP. If Texas wants to retain and attract new industries, policymakers should remove barriers for newly formed trade associations to be able to start to offer affordable coverage in a timely manner for its members. This would require a change to section 846.053.

3. Clarify a path forward for working owners. This would allow entrepreneurs and sole proprietors to participate in AHPs as contemplated under the federal rules. The statute is silent on the issue so new statutory language is required.

4. **Remove arbitrary employer participation requirement**. This should be actuarially determined by the AHP. Change Texas law in section 846.053.

5. **Eliminate extra paperwork.** Eliminate the requirement to provide notice to employees that individuals covered by the plan may be liable for expenses not paid by the plan if that is not true under the governing documents of the MEWA.

Set framework for direct health care

Texas has allowed direct primary care since 2015, but the law is primary care and physician centric.[4] Other essential providers are left out of such subscription-based direct health care (DHC) relationships that have clear benefits: Providers spend more time with patients, there is a reduction in provider burnout while increasing access—all while saving money.

Texas should update its statute to allow for non-physician direct health relationships. These agreements could be used for better diabetes management with a specialist, physical therapy, mental health treatment, dentistry, or any other ongoing medical relationship over time.

DHC agreements will increase access in rural communities and save small companies and individuals money with private insurance as they can target their insurance coverage more appropriately, saving significantly on premiums. Medicaid could save money by preventing more unnecessary emergency room visits and better chronic disease management.

Expand telemedicine to more health care practitioners

Telehealth and telemedicine can be cost-effective methods to increase access and deliver high quality care. Texas has made some recent progress in 2018 and 2019 to update its telemedicine laws, but much more is needed, given the acute access issues that exist in the state.[5]

Current Texas law is very physician centric and erects artificial barriers that prevent patients from accessing expert and quality care.[6] [7] Without reform, patients are harmed by a lack of access to more providers. Reforms should focus on expanding access to more provider types and removing barriers that make it harder for new providers to offer telemedicine.

While it is positive that Texas already allows non-physicians such as speech therapists, audiologists, mental health providers, and occupational therapists to use telemedicine, the law is still restrictive. Requirements such as only those with clients in the state being able to practice telemedicine harms future business opportunities for Texas-based providers in rural and border communities that want to specialize in telemedicine.

Broadening the law by allowing nutritionists to help with diabetes management by telemedicine, as just one example, will help many of the almost 12 percent of the adult population living with diabetes—nearly three million Texans.[8]

Telemedicine across state lines

Texas should update its telemedicine laws to allow any provider in good standing in their home state to deliver telemedicine/telehealth in Texas to increase access to care and save money for patients. While current law does allow for a pathway for some out-of-state providers to practice telemedicine in certain circumstances, the rules are still overly cumbersome and restrict patient access.[9] Texas should broaden its laws to allow more residents to access to more world-class experts or get a quick second opinion.

Protect patient access to high-value, lower-cost providers

Many high-quality, lower-cost providers have been pushed out of insurer networks, and as a result, patients are overpaying for services. Right to pick allows patients to access high-value providers, even if they are out of network, so long as they are cost effective and patients are seeing them for medically necessary covered services. In return, patients get credit toward their in-network, out-of-pocket responsibility because they have saved money, which can lead to lower health premiums in the future.

Let patients know before they go the price and pay them to shop

Health care prices can vary by hundreds or thousands of dollars for the exact same service or procedure. Granting them the right to shop allows patients to know the real price of procedures or services ahead of time to compare between options. The reform directly rewards a patient with shared savings and allows patients to access high-value providers, even if they are out of network, so long as they are cost effective and patients are seeing them for medically necessary covered services. States as diverse as Florida, Maine, Nebraska, Tennessee, and Virginia have given consumers in their states the right to shop. Utah has saved $250,000 in one year on prescription drugs only by helping public employees receive certain medication in Canada and Mexico.[10]

In addition, Texas should put into state law the Trump administration's hospital price transparency rule to require hospitals to post a machine-readable file of real prices. This protects real transparency from the whim of a future federal administration. Texas should apply disclosure to non-hospitals as well such as ASCs and urgent care facilities.

Right to pick lower drug costs

The exact same prescription drugs can often be purchased online or from independent sellers for a fraction of the cost of in-network options. If a patient buys these lower-cost options, they are penalized by their insurer as they get no credit toward their in-network, out-of-pocket responsibility. Right to pick for drugs would allow a patient to purchase a covered drug anywhere they'd like to, and if it is below the in-network average, they'd receive credit toward their in-network drug's out-of-pocket cost because they have saved money.

Allow farm bureau and related plans to enter the market

Many small companies and individuals, especially in the agricultural sector, are looking for more affordable coverage options. The states of Kansas, Iowa, Indiana, and Tennessee have passed bipartisan laws to allow well-established associations to offer alternative coverage arrangements to their members in order to provide a new affordable option.

Allow hospitals to hire qualified medical professionals that are needed

A virus can spread to health care workers, preventing them from seeing patients. Health worker shortages could be mitigated by lifting licensing restrictions that prevent qualified practitioners from working merely because they earned their license in another state or another country. State licensing and registration authorities should issue licenses to medical professionals who hold active, unencumbered licenses in good standing from other states. While licensing requirements are generally a patchwork across states, medical professions are more standardized nationally.[11] Following Arizona's lead, Texas should recognize any license for a provider who is in good standing. Without this reform Texas pays the price with less access to care and increased health care costs.

In addition, hospitals should be allowed to hire and vet foreign-trained providers from top medical programs to start working under a probationary license, with a pathway to a full license to practice. If the provider has work experience abroad, they should not be required to repeat a residency.

Update scope of practice laws

Texas should roll back regulations that prohibit medical providers (APRNs, etc.) from practicing to the full extent of their training. For example, Texas should allow nurse practitioner to practice independently, or at least allowing them to do so after two years of supervision. The state should also allow pharmacists more flexibility to modify prescriptions and prescribe tobacco cessation aids.

Protecting patients with substantial COVID-19 costs or other large medical bills

A patient's provider should give written consent that they understand a patient's credit is going to be impaired. Often providers have no idea of the long-term financial ramifications for patients. Second, a patient should have an avenue to challenge an excessive bill. Finally, if a patient has paid off a bill, or is on a payment plan a credit impairment should be removed within 30 days.

Thank you very much for the opportunity to provide these ideas for consideration.

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2 Nick Stehle and Jonathan Ingram, "Association health plans: Expanding opportunities for small business owners and entrepreneurs," Foundation for Government Accountability (2018), https://thefga.org/research/association-health-plans-small-business/.
3 TX Insurance Code Chapter 846; TX Administrative Code Title 28, Chapter 7, Subchapter S.
4 TX Occupations Code; Chapter 162; Subchapter F https://statutes.capitol.texas.gov/Docs/OC/htm/OC.162.htm
5 TX laws: H.B. 3345 and S.B. 1107
6 Christopher Collins and Sophie Novack, "Driving My Life Away," Texas Observer (2019), https://www.texasobserver.org/driving-my-life-away/
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9 TX Administrative Code, Sec. 172.12
10 Associated Press, "Utah Sending Public Employees to Mexico for Lower Prescription Prices," Fox 6 (2020),https://www.fox6now.com/news/utah-sending-public-employees-to-mexico-for-lower-prescription-prices
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